Medical Information Profile

by
Wade M. Knapp. CPS

Protective Research Group
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Introduction

Emergency medical situations can strike anyone at anytime. These emergencies can vary from simple everyday emergencies to life threatening emergencies to natural disaster emergencies. During the 1999 hurricane Floyd evacuation, it was noted that the majority of patients from home care situations reported to emergency shelters without bringing their medical information with them. In just such events, Emergency Medical Responders, such as Rescue personnel and Emergency Department nurses and physicians, require information regarding your medical history to treat you appropriately. You may not be able to relay this information to them and a family member may not be present to give information. Emergency Departments do not have immediate access to your medical records. Because of situations such as these arising, access to your medical history is very important. By keeping a detailed record of your medical history and medication list, it would be readily accessible to Emergency Medical personnel.

With the identification of this problem, we have developed the Medical Information Profile. This profile is intended for use by people who are cared for at home by family members, home health care agencies, or by anyone with an extensive medical history. It provides a simple format for you to record your medical history and medications that you are currently taking in a simple and concise manner.

By updating your Medical Information Profile **immediately** anytime there are changes in your medical conditions or changes in your medications, you will have a complete health history available when needed. Your Medical Information Profile should be available for easy access by yourself and your family members. In the event of any emergency at home, it should be given to Rescue personnel and/or taken to the Emergency Department with you anytime you are seeking emergency care. As well, your Medical Information Profile should also be taken with you anytime you are traveling, in the event you should need to seek medical attention while out of town.

* This medical information profile has been designed for emergency uses and should not be considered a complete patient medical history, and should not be considered a replacement for standard medical records.

Personal Information

First Name	Last Name	MI
_____	_____	_____

Address _____

_____

Telephone Number _____

Date of Birth _____ Sex _____ Blood Type _____

Height _____ Weight _____ Social Security Number _____

Medical Insurance Carrier _____ Group Number _____

Next of Kin (name) _____

Relationship _____ Telephone Number _____

Address _____

Additional Family Member (name) _____

Relationship _____ Telephone Number _____

Address _____

Additional Family Member (name) _____

Relationship _____ Telephone Number _____

Address _____

Additional Family Member (name) _____

Relationship _____ Telephone Number _____

Address _____

Physician Information

Name of Primary Care Physician _____

Address _____

Telephone Number _____ Fax Number _____

Name of Consulting Physician _____

Address _____

Telephone Number _____ Fax Number _____

Reason For Seeing This Physician _____

Name of Consulting Physician _____

Address _____

Telephone Number _____ Fax Number _____

Reason For Seeing This Physician _____

Name of Consulting Physician _____

Address _____

Telephone Number _____ Fax Number _____

Reason For Seeing This Physician _____

Name of Consulting Physician _____

Address _____

Telephone Number _____ Fax Number _____

Reason For Seeing This Physician _____

Allergies

Penicillin ☐ YES ☐ NO

Sulfa ☐ YES ☐ NO

Insect (bees, spiders) ☐ YES ☐ NO

Seafood (Iodine) ☐ YES ☐ NO

Other: _____

_____

Past Medical History

Heart Disease ☐ YES ☐ NO

High Blood Pressure ☐ YES ☐ NO

Diabetes ☐ YES ☐ NO (☐ Insulin ☐ Pills ☐ Diet Control)

Cancer ☐ YES ☐ NO (Chemotherapy ☐YES ☐NO)

Seizures (Epilepsy) ☐ YES ☐ NO

Asthma ☐ YES ☐ NO (☐ Inhaler ☐ Steroids)

Pulmonary Disease ☐ YES ☐ NO (☐ Emphysema ☐ Asthma ☐ Bronchitis)

Congestive Heart Failure ☐ YES ☐ NO

Stroke ☐ YES ☐ NO

Bleeding Abnormalities ☐ YES ☐ NO

Anemia ☐ YES ☐ NO

Ulcer ☐ YES ☐ NO

Immune Disorder ☐ YES ☐ NO
(HIV / AIDS)

Arthritis ☐ YES ☐ NO

Hepatitis / Liver Disease ☐ YES ☐ NO

Kidney Disease ☐ YES ☐ NO

Parkinson's Disease ☐ YES ☐ NO

Thyroid Disease ☐ YES ☐ NO

Dementia (Alzheimer's) ☐ YES ☐ NO

Hiatal Hernia ☐ YES ☐ NO

Esophageal Reflux ☐ YES ☐ NO

Other Condition or Disease: _____

_____

_____

Surgeries

☐ Appendix
☐ Hysterectomy
☐ Gallbladder
☐ Heart
☐ Bypass Grafts
☐ Heart Valve Replacement
☐ Hernia
☐ Spleen

Other Surgeries ☐ YES ☐ NO
(List)

_____

_____

_____

_____

_____

Medical History

Do You Smoke? - ☐YES ☐ NO

How Many Years _____
Packs per Day _____

Are You Vision Impaired? - ☐YES ☐ NO

☐ Slight Impairment
☐ Blind

Do You Wear Glasses? - ☐YES ☐ NO
(What Is The Reason For Wearing Glasses?)

☐ Reading Only
☐ Cataracts
☐ Near Sighted
☐ Far Sighted

Are You Hearing Impaired? - ☐YES ☐ NO

☐ Slight Impairment
☐ Completely Deaf

Do You Wear Hearing Aid(s)? - ☐YES ☐ NO

☐ Left Ear
☐ Right Ear
☐ Bilateral

Do You Wear Dentures? - ☐YES ☐ NO

☐ Full
☐ Partial(s)
☐ Upper
☐ Lower

Are You On A Special Diet? - ☐YES ☐ NO

What Type_____

Are You Able To Walk? - ☐YES ☐ NO

Do You Require Assistance to Walk? - ☐YES ☐ NO

☐ Cane
☐ Crutches
☐ Walker
☐ Wheelchair

Are You Speech Impaired? - ☐YES ☐ NO

☐ Slight Impairment
☐ Unable To Speak

Bathing Needs? -

☐ No Assistance
☐ Supervision
☐ Assistance
☐ Bed Bath
☐ Tub
☐ Shower
☐ Sponge Bath

Toileting Needs? -

☐ No Assistance
☐ Bathroom Assistance
☐ Bedpan

Bladder Control? -

☐ Continent
☐ Slight Incontinence
☐ Total Incontinence
☐ Catheter

Bowel Control? -

☐ Continent
☐ Slight Incontinence
☐ Total Incontinence
☐ Ostomy

Feeding? -

☐ No Assistance
☐ Assistance with Feeding
☐ Aspiration Precautions

Dressing Needs? -

☐ Dresses Self
☐ Minor Assistance
☐ Has to be Dressed

Date Of Last Tetanus Shot _____

Additional Notations _____

_____

Medications

Prescription Medications Currently Being Used:
(Mark through medications which are no longer used.)

Name of Medication	Dosage Amount	How Many Times A Day

Medications

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(Mark through medications which are no longer used.)

Name of Medication	Dosage Amount	How Many Times A Day

Over the Counter Medications Used:

Aspirin ☐ YES ☐ NO

Motrin (Ibuprofen) ☐ YES ☐ NO

Tylenol ☐ YES ☐ NO

Other: _____

_____

_____

_____

_____

Family Medical History

Heart Disease	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
High Blood Pressure	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Cancer	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Diabetes	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Stroke	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Aneurysm	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Other Disease or Condition:				
_____	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
_____	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
_____	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent

Special Medical Requirements

Oxygen ☐ YES ☐ NO

Liters per Minute _____
☐ Nasal Cannula
☐ Mask
☐ Only when needed
☐ Continuous

Suctioning ☐ YES ☐ NO Frequency _____

Ostomy Care ☐ YES ☐ NO Frequency _____

(Ostomy supplies used _____)

Trach Care ☐ YES ☐ NO Frequency _____

Size _____

Tube Feedings ☐ YES ☐ NO Frequency _____

Type _____

Change Feeding Tube ☐ YES ☐ NO Frequency _____

Catheter (Urinary) ☐ YES ☐ NO Size _____

Type _____

(Date catheter last changed _____)

Irrigate Catheter ☐ YES ☐ NO Frequency _____

Solution _____

Wound Care ☐ YES ☐ NO

(Wound Location _____)

Wound Dressing Type _____

Frequency _____

Nebulizer Therapy ☐ YES ☐ NO Frequency_____

Medication_____

Are You A Dialysis Patient? ☐ YES ☐ NO

☐ **Hemodialysis**

Location Of Fistula? _____

What Days Do You Go For Dialysis? _____

Where Do You Go For Dialysis? _____

☐ **Peritoneal Dialysis**

Type Of Set-Up Used _____

Type Of Fluid Used _____

How Often Do You Make Exchange? _____

Do You Rely Upon Someone To Care For You At Home? ☐ YES ☐ NO

☐ Family Member ☐ Other Care-giver

What Kind Of Care Is Provided? _____

_____

_____

Are You Visited By A Home Health Care Nurse? ☐ YES ☐ NO

Agency Name_____ Telephone Number _____

For What Reason Does The Health Care Agency Nurse Visit You?

_____

_____

Additional Important Medical Information:

Additional Important Medical Information:

Additional Important Medical Information: